U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 06 June 2006

Case No: 2003-BLA-0290

In the Matter of

ERMA L. KIRKLING, Widow of
DON S. KIRKLING, Deceased Miner

Claimant

v.

PEAB0DY COAL COMPANY

Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS

Party-in-Interest

APPEARANCES:

Thomas E. Johnson, Esq.
JOHNSON, JONES, SNELLING, GILBERT
& DAVIS, P.C.
Chicago, Illinois
For the Claimant

Scott A. White, Esq.
WHITE & RISSE, L.L.P.
St. Louis, Missouri
For the Employer/Carrier

BEFORE: RUDOLF L. JANSEN
Administrative Law Judge

DECISION AND ORDER — AWARDING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended. 30 U.S.C. § 901 *et seq.* Under the Act, benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis also may recover benefits. Pneumoconiosis, commonly known as black lung, is defined in the Act as "a chronic dust disease of the lung and its sequelae, including pulmonary and respiratory impairments, arising out of coal mine employment." 30 U.S.C. § 902(b).

On September 19, 2003, this case was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was held in Terre Haute, Indiana on October 25, 2005.[1] However, prior to the hearing, the parties agreed to have the claim decided on the existing record.[2] Employer did not object to this request. Accordingly, I granted the parties' request and made the record in this proceeding.

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. They also are based upon my observation of the appearance and demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit received into evidence has been reviewed carefully, particularly those related to the miner's medical condition. The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to "DX", "EX", and "CX" refer to the exhibits of the Director, Employer, and Claimant, respectively. The parties' joint exhibit is cited as "JX."

[1] At the hearing, the record was held open until December 12, 2005 to allow the parties to submit post-hearing briefs. Based on the parties' requests, I extended the deadline date on four separate occasions and set a final brief due date of January 13, 2006. Claimant and the Employer both submitted a brief within the allotted time. The record is now closed.

[2] The parties also agreed that neither the Claimant nor her attorney, Thomas E. Johnson, would be present at the hearing. (Hearing Transcript "Tr." 5).

The Notice of Hearing and Pre-hearing Order gave direction to the parties concerning the matters to be considered in the briefing of the issues involved in this case. The briefing order indicates as follows:

> Any ISSUE not specifically addressed on brief will be considered abandoned by that party for decisional purposes. Each party will make specific, all inclusive FINDINGS OF FACT with respect to each issue being briefed.
>
> All contentions concerning fact and law as to individual issues which are not made on brief will be considered waived. The absence of FACTUAL FINDINGS or arguments concerning record evidence will constitute an admission that they are of no importance in the disposition of the issue and that the party has abandoned any contention concerning the applicability of the ignored evidence to the pertinent issue.

The directive includes the warning that if a party fails to fully argue an issue or to make complete factual findings concerning that issue, that they have waived any consideration as to the argument or as to the facts, and have abandoned the matter in its entirety, both factually and legally, as a result of the omission.

The issues and facts being discussed in this opinion are those which have been raised by the parties. All other legal and factual contentions are considered abandoned.

ISSUES

The following issues remain for resolution:

1. Whether the Miner had pneumoconiosis as defined by the Act and regulations;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment; and

3. Whether the Miner's death was due to pneumoconiosis.

The Employer also contests other issues relating to the constitutionality of the Act and regulations. (DX 51). These issues are beyond the authority of an administrative law judge and are preserved for appeal purposes only.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

Don S. Kirkling, Claimant's deceased husband and the Miner upon whom this claim is based, was born on August 5, 1925 and died on January 17, 1999. (DX 2). Claimant, Erma L. Corbin, and the Miner were married on June 12, 1948 (DX 5), and they resided together until the Miner's death (DX 2). They have no children who were under eighteen or dependent upon them at the time this claim was filed. (*Id.*). At the time of the hearing, Claimant resided in Clay City, Indiana and had not remarried. (DX 2).

During the adjudication of the Miner's claim, I determined that the Miner smoked cigarettes from approximately age 21 until he was 68 years old. (DX 1). He smoked two packs of cigarettes a day for 20 years and then decreased consumption to one pack a day until he finally quit in 1993. (DX 1).

Claimant timely filed her application for survivor's benefits on June 18, 1999. (*Id.*). The Office of Workers' Compensation Programs (OWCP) denied benefits on December 13, 1999. (DX 19). After an informal conference was held and pursuant to Claimant's request for a formal hearing (DX 32), the case was transferred to the Office of Administrative Law Judges (OALJ) on December 15, 2000 (DX 34). However, on September 26, 2000, I granted Employer's Motion to Remand the claim to the District Director for proper assimilation of the Director's Exhibits. (DX 36). On January 24, 2001, the OWCP transferred the claim to the OALJ for a formal hearing. (DX 42). At the hearing on April 23, 2003, Claimant requested more time to find an attorney to develop the medical evidence in her claim. Therefore, on April 24, 2003, I granted Claimant's request to remand the claim to the District Director. (DX 43). The OWCP denied benefits on July 2, 2003. (DX 50). Pursuant to Claimant's request for a formal hearing (DX 52), the case was transferred to the Office of Administrative Law Judges on September 19, 2003 (DX 57). Thereafter, the parties agreed to have the case heard on the existing record.

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. At the Miner's hearing on October 19, 1993, I found that the Miner worked 42 years in qualifying coal mine work, all above ground. (DX 1). This finding was based on my review of the record and the Employer's stipulation. (*Id.*). As this issue was not contested in the widow's claim, I adopt my finding from the Miner's Decision and credit the Miner with 42 years of qualifying coal mine employment. During the Miner's last seven to eight years of coal mine employment, he worked as a truck driver.[3] (CX 24).

MEDICAL EVIDENCE[4]

X-ray reports

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 39	04/25/86	04/25/86	Carr/none	Unable to rule out focal atelectasis or a small pleural effusion.
DX 39	11/18/88		Bouffard/R	Evidence of interstitial prominence on both lower lung fields.
DX 39	11/01/90	11/01/90	Lambertus/BCR	Negative
DX 39	11/01/90	11/01/90	Lambertus/BCR	No evidence of active cardiopulmonary disease.
DX 40	11/01/90	11/11/91	Gogineni/BCR, B	Negative
DX 39	11/01/90	11/20/90	Cole/BCR, B	0/1
DX 39	11/01/90	09/23/91	Renn/B	Negative
DX 40	11/01/90	10/01/91	Morgan/none	Completely Negative
DX 40	11/01/90	10/23/91	Lapp/B	Negative

[3] This case arises within the jurisdiction of the United States Court of Appeals for the Seventh Circuit because Claimant's last coal mine employment occurred in Indiana. *See Shupe v. Director, OWCP,* 12 BLR 1-200, 1-202 (1989)(*en banc*).

[4] The parties submitted a Joint Stipulation which designated the medical evidence for the survivor's claim. (JX 1).

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 40	11/01/90	11/15/91	Wershba/ BCR, B	Negative
DX 40	12/06/90	11/29/91	Gogineni/ BCR, B	Negative
DX 40	12/06/90	12/03/91	Hayes/none	Negative
DX 40	12/06/90	12/06/91	Binns/ BCR, B	Negative
DX 40	12/06/90	01/05/92	Morgan/none	Negative
DX 40	12/06/90	01/14/92	Lapp/B	Negative
DX 40	12/06/90	04/14/92	Laucks/none	0/1
DX 40	12/06/90	05/08/92	Duncan/none	Negative
DX 40	12/06/90	05/19/92	Robinson/none	0/1
DX 40	12/06/90	07/10/92	Renn/B	Negative
DX 40	12/06/90	07/10/92	Repsher/B	Negative
DX 39	08/27/91	09/23/91	Renn/B	Negative
DX 40	08/27/91	10/01/91	Morgan/none	Completely Negative
DX 40	08/27/91	10/23/91	Lapp/B	Negative
DX 40	08/27/91	11/11/91	Gogineni/BCR, B	Negative
DX 40	08/27/91	11/12/91	Binns/BCR, B	0/1
DX 40	08/27/91	11/15/91	Wershba/BCR, B	Negative
CX 1	08/27/91	01/14/92	Ahmed/BCR, B	1/1
CX 2	08/27/91	03/27/92	Alexander/B	1/0
CX 3	08/27/91	01/16/92	Aycoth/B	1/1
CX 5	08/27/91	01/20/92	Pathak/B	1/1
CX 4	08/27/91	01/29/92	Cappiello/B	1/1
CX 6	08/27/91	04/16/92	Fisher/BCR, B	1/1
CX 9	08/27/91	05/13/92	Bassali/BCR, B	2/3
DX 40	08/27/91	07/01/92	Morgan/none	Completely Negative
CX 17	04/07/92	05/14/92	Marshall/BCR, B	1/1

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
CX 14	04/07/92	07/01/92	Alexander/B	1/1
CX12	04/07/92	07/07/92	Ahmed/BCR, B	1/0
CX 15	04/07/92	07/14/92	Cappiello/B	1/1
CX 16	04/07/92	07/21/92	Pathak/B	1/1
CX 13	04/07/92	07/22/92	Alexander/B	1/1
DX 40	04/07/92	11/09/93	Wershba/BCR, B	Negative
DX 40	06/22/92	06/23/92	Pruitt/none	1/1
DX 40	06/22/92	08/17/92	Wershba/BCR, B	Negative
DX 40	06/22/92	08/18/92	Hayes/none	0/1
DX 40	06/22/92	08/21/92	Gogineni/BCR, B	0/1
DX 40	06/22/92	08/26/92	Abramowitz/none	0/1
DX 40	06/22/92	10/01/92	Laucks/none	0/1
DX 40	06/22/92	10/07/92	Robinson/none	0/1
DX 40	06/22/92	10/02/92	Duncan/none	0/1
DX 40	06/22/92	01/30/93	Repsher/B	Unreadable
DX 40	07/30/93	09/24/93	Aycoth/B	½
CX 20	07/30/93	09/29/93	Ahmed/BCR, B	1/1
CX 21	07/30/93	10/05/93	Cappiello/B	½
DX 40	07/30/93	11/08/93	Binns/BCR, B	Negative
DX 40	07/30/93	11/09/93	Wershba/BCR, B	Unreadable
DX 40	07/30/93	01/13/94	Repsher/B	Unreadable
DX 10	09/30/94	09/21/99	Gaziano/BCR, B	Negative

"B" denotes a "B" reader, "R" denotes a radiologist, and "BCR" denotes a board-certified radiologist. A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services (HHS). A board-

certified radiologist is a physician who is certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association. *See* 20 C.F.R. § 718.202(a)(ii)(C).

Pulmonary Function Studies[5]

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV1/ FVC	Tracings	Comments
DX 39 04/30/84	Lenyo	58/67.5"	2.31	3.11	42	74%		
DX 39 07/14/92	Long							Determined that test dated 04/30/84 was invalid.
DX 39 06/22/92	Paul							Determined that test dated 04/30/84 was invalid.
DX 39 07/03/92	Vest							Determined that test dated 04/30/84 was invalid.
DX 39 07/07/92	Renn							Determined that test dated 04/30/84 was invalid.
DX 39 11/06/85	Lenyo	60/67.5"	1.61	2.93	47	54%		

[5] As there is a discrepancy in the measured height of Claimant among the pulmonary function studies, I must make a finding resolving that discrepancy. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). There are eight reported heights of 67 inches, which represent the majority, and three reported heights of 67.5 inches, and one reported height of 66, 68, and 72 inches. Therefore, I find that the majority of the evidence supports a finding that he is 67 inches.

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV1/ FVC	Tracings	Comments
DX 40 07/14/92	Long							Determined that test dated 11/06/85 as invalid.
DX 39 06/22/92	Paul							Determined that test dated 11/06/85 was invalid.
DX 40 07/03/92	Vest							Determined that test dated 11/06/85 was invalid.
DX 40 07/07/92	Renn							Determined that test dated 11/06/85 as invalid.
DX 39 11/18/88	Combs	63/67"	1.55 *1.55	2.15 *2.12	45/ *66	74% *63%		Good Effort
DX 40 12/05/91	Paul							Determined that test dated 11/18/88 was invalid.
DX 40 12/27/91	Vest							Determined that test dated 11/18/88 was invalid.
DX 40 12/31/91	Long							Determined that test dated 11/18/88 was invalid.
DX 40 01/06/92	Anderson							Determined that test dated 11/18/88 was invalid.

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV1/ FVC	Tracings	Comments
DX 40 02/27/92	Renn							Determined that test dated 11/18/88 was invalid.
DX 39 11/01/90	Pangan	65/67"	1.33	1.45		91%		Questioned whether test was performed with maximal effort.
DX 40 11/27/90	Long							Determined that test dated 11/01/90 was invalid.
DX 39 12/06/90	Lenyo	65/72"	0.78	1.21	28	64%		
DX 40 10/12/91	Long							Determined that test dated 12/06/90 was invalid.
DX 40 12/05/91	Paul							Determined that test dated 12/06/90 was invalid.
DX 40 12/27/91	Vest							Determined that test dated 12/06/90 was invalid.
DX 40 01/06/92	Anderson							Determined that test dated 12/06/90 was invalid.
DX 40 02/27/92	Renn							Determined that test dated 12/06/90 was invalid.

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV1/ FVC	Tracings	Comments
DX 39 12/20/90	Pangan	65/67"	1.25	1.66		75%		
DX 40 01/08/91	Long							Determined that test dated 12/20/90 was invalid.
DX 39 08/29/91	Cook	66/67"	1.08 *1.13	1.24 *1.30		87% *86%		
DX 39 09/03/91	Cook							Determined that test dated 08/29/91 was invalid.
DX 40 10/12/91	Long							Determined that test dated 08/29/91 was invalid.
DX 40 12/05/91	Paul							Determined that test dated 08/29/91 was invalid.
DX 40 12/27/91	Vest							Determined that test dated 08/29/91 was invalid.
DX 40 01/06/92	Anderson							Determined that test dated 08/29/91 was invalid.
DX 40 02/27/92	Renn							Determined that test dated 08/29/91 was invalid.

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV1/ FVC	Tracings	Comments
DX 40 11/20/91	Combs	66/67"	1.06	1.57	33	67%		
DX 40 06/08/92	Long							Determined that test dated 11/20/91 was invalid.
DX 40 06/11/92	Paul							Determined that test dated 11/20/91 was invalid.
DX 40 06/12/92	Vest							Determined that test dated 11/20/91 was invalid.
DX 40 06/18/92	Renn							Determined that test dated 11/20/91 was invalid.
DX 40 07/07/92	Lenyo	67/66"	1.12 *1.16	1.26 *1.55	33 *29	88% *74%		Severe restrictive Lung disease.
DX 40 06/08/92	Long							Determined that test dated 04/07/92 was invalid.
DX 40 06/11/92	Paul							Determined that test dated 04/07/92 was invalid.
DX 40 06/12/92	Vest							Determined that test dated 04/07/92 was invalid.

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV1/ FVC	Tracings	Comments
DX 40 06/18/92	Renn							Determined that test dated 04/07/92 was invalid.
DX 40 06/22/92	Howard	66/67"	0.91 *1.11	1.52 *1.31	24 *17	59% *84%		Did not exert maximal effort
DX 40 08/17/92	Paul							Determined that test dated 06/22/92 was invalid.
DX 40 08/27/92	Renn							Determined that test dated 06/22/92 was invalid.
DX 40 08/31/92	Long							Determined that test dated 06/22/92 was invalid.
DX 40 09/11/92	Vest							Determined that test dated 06/22/92 was invalid.
CX 18 07/30/93	Rosecan	67/67"	1.22 *0.94	1.51 *0.79	20.6 *26.4	80% *118%		
DX 9 06/11/96	Lenyo	70/68"	0.79 *0.83	0.92 *0.93	32 *22	85% *89%		Severe restrictive lung disease.
DX 9 07/14/97	Lenyo/ Phillipson	71/67"	1.13	1.37	26	82%		

*post-bronchodilator values

Arterial Blood Gas Studies

Exhibit	Date	Physician	pCO2	pO2	Resting/ Exercise
DX 39	11/18/88	Combs	41.1	73.0	Resting
DX 39	11/01/90	Pangan	35.2	76.4	Resting
			34.3	91.7	Exercise
DX 39	12/05/90	Simpao	34	80	Resting
DX 40	04/07/92	Lenyo	36	75	Resting
DX 40	06/22/92	Howard	36	73	Resting
			34	83	Exercise
DX 9	06/11/96	Lenyo	36	75	Resting

Death Certificate:

Dr. Steve Phillipson signed the Miner's Certificate of Death. (DX 7). The immediate causes of death were listed as hemorrhage, cancer of larynx, occupational exposure to carcinogens, Black Lung disease, and tobacco use. The Death Certificate provides no other medical evidence relating to the causes of the Miner's death. Neither the Death Certificate nor the record provides any information concerning whether Dr. Phillipson has any specialty medical credentials.

Pathology Evidence

Dr. Heidingsfelder

On January 17, 1999, Dr. John A. Heidingsfelder, who is a Forensic Pathologist, performed an autopsy of the Miner's thorax area. (DX 8). He noted that the Miner had a coal mine employment history of 44 years. Gross examination of lungs revealed: a moderate number of right pleural fibrous adhesions; a nodular pattern of fibrous plaque formation present on parietal pleural surface of the right anterior chest wall; multiple regions of interstitial bluish-gray anthracotic pigment deposition; marked anthracotic pigment deposition throughout essentially all pulmonary lobes; and multiple pulmonary blebs and bullae present over the pleural surface of the lungs.

Dr. Heidingsfelder's microscopic examination of the lung tissue was submitted as a separate exhibit. (DX 35). He noted that the slides revealed multiple foci regions of anthracosis mixed with pulmonary fibrosis and anthracotic fibrotic nodules. Based on his examination of the slides, he diagnosed the Miner with the following:

1. Pulmonary anthracosis, marked.

2. Multiple pulmonary anthracotic-fibrotic lesions with localized emphysema (anthracotic macules).

3. Chest wall dense fibrous plaque formations and anthracotic chest wall lesions.

4. Pleural fibrous adhesions.

5. Extensive pleural, subpleural and interstitial fibrotic changes of lung tissue.

6. Pulmonary emphysema, marked.

7. Peripheral adenosquamous carcinoma of the lung with focal scar formation and central anthracotic nidus.

8. Lymph nodal anthracosis and fibrohilar nodule formation.

On March 22, 2000, Dr. Heidingsfelder issued a one page letter titled Addendum Comment. (DX 27). He noted the following:

> Review of [D]eath [C]ertificate and additional clinical information provided in letter by Dr. Lenyo to Claims Examiner dated February 22, 2000, indicates to me that the Black Lung disease noted in Mr. Kirkling at the time of my post mortem examination is a contributing factor to the cause and timing of death in this case.

Dr. Naeye

On October 20, 1999, Dr. Richard L. Naeye issued a consultative report after reviewing the Miner's medical records, including: the autopsy report, a copy of the Death Certificate, claim forms, and the 16 glass autopsy slides. (DX 16). He

considered a coal mine employment history of 43.6 years in above ground strip mining and noted that he had a 100 plus pack-year history of cigarette smoking. He determined that the evidence was insufficient to diagnose the Miner with coal workers' pneumoconiosis ("CWP"). He concluded that slides revealed a small amount of black pigment in about one-half of the lung sections, severe emphysema, and large areas of fibrosis. He opined that the Miner died from a metastatic carcinoma that originated in his larynx, which was caused by his smoking history. He believed that the Miner would have died at the same time and in the same way if he had never mined coal. He noted that there was no evidence that suggests that above ground coal mine dust predisposes an individual to the development of throat cancer. Dr. Naeye is board-certified in Anatomical and Clinical Pathology.

Dr. Katzman

On November 19, 1999, Dr. Richard A. Katzman issued a consultative opinion. (DX 18). He opined that the Miner's death was due to a restrictive lung disease and CWP.

On May 11, 2000, Dr. Katzman issued a second consultative report after reviewing additional medical evidence. (DX 28). He diagnosed the Miner with a small amount of coal worker's pneumoconiosis and determined that the disease did not cause, aggravate, or accelerate his death. Dr. Katzman is board-certified in Internal Medicine.

Dr. Caffrey

Dr. P. Raphael Caffrey reviewed the Miner's medical records, including the autopsy report, the 16 autopsy slides, and the Death Certificate, and issued a consultative report on November 2, 1999. (DX 17). Based on his review of the autopsy slides, he diagnosed Mr. Kirkling with the following:

I. RESPIRATORY SYSTEM
   - A. Diffuse, keratinzing, squamous cell carcinoma with necrosis and focal fibrosis.
   - B. Panlobular and centrilobular emphysema, severe.
   - C. Focal, subpleural bullae with focal subpleural fibrosis.
   - D. Simple coal workers' pneumoconiosis, minimal.

E. Moderate amount of anthracotic pigment with micronodules identified in hilar lymph nodes.

II. HEART
A. Cardiomegaly, mild.

In the second half of Dr. Caffrey's report, he summarized the medical evidence he was asked to review. He noted that the Miner worked 43 years and seven months in strip coal mining operations and that he smoked one to two packs of cigarettes a day, off and on, for 40 years. Based on his review of the medical data, he opined that Mr. Kirkling had a minimal degree of simple coal workers' pneumoconiosis. However, he determined that the disease was not sufficient to have made him disabled or contribute to his death. He determined that the medical records revealed that the Miner suffered from heart disease. He opined that the Miner's pulmonary problems resulted from his emphysema and squamous cell carcinoma, which was due to his smoking history. Dr. Caffrey is board-certified in Anatomical and Clinical Pathology.

Dr. Caffrey was deposed on November 8, 2004. (EX 16). In preparation for his deposition, he reviewed the medical reports of Drs. Naeye, Hutchins, Oesterling, Green, and Tomashefski. He affirmed his findings from his written report dated November 2, 1999. He stated that since the Miner's simple pneumoconiosis only made up less than five percent of his lung tissue, the disease did not have any deleterious effect on his lungs. He disagreed with Dr. Green's diagnosis of nodular pneumoconiosis because he did not see any lesion of simple CWP with collagen on the autopsy slides. He also disagreed with Dr. Green's opinion that the Miner's emphysema was due to both smoking and coal dust exposure. He also found problems with Dr. Green's statement that interstitial fibrosis was a form of CWP. He believed that the Miner's fibrosis was related to his cancer and emphysema and not coal dust exposure. He opined that Miner would have died from smoking despite working in the coal mines.

Dr. Hutchins

Dr. Grover M. Hutchins reviewed the autopsy report and the 16 autopsy slides and issued a consultative report on February 11, 2000. (DX 26). He noted that the Miner worked 42 years and seven months in surface coal mining and that he smoked cigarettes for 40 years at the rate of up to three packs a day, reducing his consumption in the 1990's. He noted that the

autopsy slides showed a small number of macules of CWP but not progressive massive fibrosis. He also noted that the lung tissue showed severe centrolobular, panacinar, and bullous emphysema. Therefore, he opined that the Miner had a mild degree of simple CWP. However, he determined that the disease was too slight to have contributed to his death. He concluded that the Miner's major pulmonary problems were his severe emphysema, metastatic carcinoma of the larynx, and interstitial fibrosis. He opined that the Miner's emphysema and cancer were due to his heavy smoking history. He found no evidence to suggest that CWP or coal dust exposure were associated with the development of cancer of the larynx or the type of emphysema or interstitial fibrosis the Miner had. Dr. Hutchins is board-certified in Anatomic and Pediatric Pathology.

Dr. Green

On May 16, 2003, Dr. Francis H.Y. Green reviewed the Miner's medical records, including the Miner's autopsy slides and report. (DX 46). Based on his review of the autopsy slides, he diagnosed the Miner with the following:

1. Simple coal worker[s'] pneumoconiosis comprising macules, nodules and interstitial fibrosis, overall severity severe.

2. Focal and centriacinar emphysema, moderately severe.

3. Metastatic squamous cell carcinoma.

4. Silicotic nodules in tracheo-bronchial lymph nodes.

Upon reviewing the Miner's medical records, Dr. Green noted that the Miner worked 43 years in surface coal mining and had a smoking history of 40 to 80 pack years. He determined that the Miner's emphysema was due to cigarette smoking and exposure to coal dust. He determined that the Miner's lung disease, interstitial fibrosis, was a form of CWP and that it accounts for the irregular small opacities seen in some of the Mr. Kirkling's x-rays. He disagreed with Dr. Rosenberg's diagnosis of idiopathic pulmonary fibrosis ("IDF") because the disease was present nine years before the Miner's death and the natural history of the Miner does not fit the pattern of the disease. He opined that the Miner's death was due to a combination of pneumoconiosis and metastatic laryngeal carcinoma. Dr.

Rosenberg believed that the cancer was a result of the Miner's smoking history. He explained that exposure to coal dust caused the Miner's lung disease, which was a major contributing factor to Mr. Kirkling's death.

On October 5, 2005, Dr. Green reviewed additional medical records and issued an addendum to his May 16, 2003 report. (CX 30). He concluded again that the Miner's pneumoconiosis was a major contributing factor to his death. He opined that the Miner died of a number of factors, including: metastatic laryngeal cancer, severe emphysema, and pneumoconiosis. He explained that since the pulmonary function tests were found to be invalid, the pathological material is critical in establishing that the Miner's death was due to pneumoconiosis. Dr. Green is board-certified in Anatomic Pathology. (CX 31).

Dr. Oesterling

On February 6, 2002, Dr. Everett F. Oesterling, Jr., reviewed the Miner's medical records, including the autopsy slides, and issued a consultative report. (EX 1). Based on his review of the autopsy slides, he determined that the Miner had mild macular CWP and a very low level of simple CWP. However, he opined that the Miner's respiratory impairment and death was not caused by the disease. He noted that his opinion was consistent with the opinions of Drs. Caffrey and Naeye but divergent from Dr. Heidingsfelder, who he believed had misinterpreted metastatic nodules for those of coal workers' pneumoconiosis. Dr. Oesterling determined that the amount of fibrous tissue with black tissue in the Miner's lungs could not have produced the extensive reactive change within Mr. Kirkling's pleura. "Thus[,] the pleura disease which was present on x-rays and was described by the prosector is unrelated to this gentleman's coal dust exposure." He also diagnosed the Miner with moderately severe bullous emphysema caused by cigarette smoking, since he found no coal dust in the emphysema fields. Dr. Oesterling is board-certified in Anatomical and Clinical Pathology and Nuclear Medicine. (EX 4).

Dr. Oesterling was deposed on April 11, 2003. (EX 13). He opined that as a result of the Miner's throat cancer, Mr. Kirkling developed metastatic nodules in his lung tissue. He believed that the Miner had some emphysema but concluded that it was not sufficient enough to be a significant disease in terms of his final disease processes. However, it would have probably caused the Miner to have shortness of breath. He attributed the Miner's throat cancer to alcohol and tobacco use.

Dr. Tomashefski

Dr. Joseph F. Tomashefski, Jr., conducted an extensive review of the Miner's medical records, including the autopsy report and slides, and issued a consultative report on March 20, 2002. (EX 3). He noted that the Miner was a heavy cigarette smoker with a lifetime exposure of 70 to 100 pack years. He also noted that he worked as a coal miner for 44 years, exclusively on strip mines. He noted that a review of Mr. Kirkling autopsy slides of his heart and arteries showed "well-preserved myocardium and severe calcific coronary atherosclerosis . . . [and] excludes right ventricular hypertrophy and cor pulmonale." A review of slides containing lung tissue showed multiple metastatic nodules of carcinoma in the lung parenchyma and visceral pleura. Specifically, he found advanced interstitial fibrosis in the lung parenchyma, mild deposition of fine black pigment in the visceral pleura and around vessels and airways, and one coal macule.

Dr. Tomashefski determined that a finding of one coal macule was not enough to substantiate a diagnosis of CWP. Therefore, he concluded that pneumoconiosis did not contribute to the Miner's death or cause the Miner to have any respiratory symptoms or respiratory dysfunction. He diagnosed the Miner with severe centriacinar emphysema and/or advanced interstitial fibrosis. Although he was unable to determine the cause of the Miner's lung disease, he opined that it was not asbestosis or CWP. Based on his review of the medical data and autopsy evidence, he opined that the major cause of the Miner's death was metastatic squamous cell carcinoma of the larynx with lung involvement. He concluded that cigarette smoking caused the Miner's cancer and emphysema and was a major risk factor for his heart disease. Dr. Tomashefski is board-certified in Anatomic and Clinical Pathology.

Dr. Tomashefski was deposed on April 9, 2003. (EX 11). He stated that the carcinoma, emphysema, and fibrosis lesions were present in many, if not all, of the slides he reviewed, which signifies that those conditions were extensive, assuming multiple areas of the lungs were sampled. He stated that the slides showed evidence of silicotic nodules but determined that the Miner did not have silicosis. He found no evidence of complicated CWP or progressive massive fibrosis. Based on his review of the pathology evidence and the medical records, he opined that the Miner did not have pneumoconiosis with cor pulmonale. He concluded that the Miner died mainly from

metastatic carcinoma of the larynx. However, severe emphysema and interstitial fibrosis contributed to his respiratory failure and his death. He stated that even assuming that the Miner had CWP, it would not have been sufficient to have contributed to his death.

Narrative Medical Evidence

Dr. Combs

Dr. Daniel J. Combs examined the Miner and issued a report on December 13, 1988. (DX 39-22). He noted that the Miner worked as a surface coal miner for 43 years and smoked two packs of cigarettes a day for 40 years. He conducted a pulmonary function study and an arterial blood gas study. He diagnosed the Miner with an interstitial lung disease and chronic bronchitis due to smoking.

On May 21, 1992, Dr. Combs issued a one page consultative report. (CX 8). He determined that based on the Miner's history of coal mine work and length of exposure to coal dust, Mr. Kirkling had pneumoconiosis. He also determined that the Miner was unable to perform his previous work in the coal mines as it would have aggravated his symptoms.

On July 28, 1992, Dr. Combs issued another one page medical report. (CX 11). He considered a coal mine employment history of 30 years and noted that the Miner smoked less than a pack of cigarettes a day. He noted that he reviewed an x-ray revealing simple pneumoconiosis 1/1 but failed to provide any evidence as to when the x-ray was taken. He diagnosed the Miner with emphysema, chronic bronchitis, and CWP.

Dr. Combs was deposed on December 7, 1993. (CX 23). He opined that the pulmonary function study performed on November 18, 1988 was valid and accurately reflected the Miner's actual level of pulmonary capacity. He stated that on November 20, 1991, he administered a second pulmonary function test to the Miner and those results were also accurate. Based on the latest results, he diagnosed the Miner with pneumoconiosis, chronic bronchitis, and COPD.

In January 1992, he examined the Miner and reviewed the results of the objective testing from Dr. Lenyo's medical examination. He concluded that the Miner had pulmonary function abnormalities secondary to pneumoconiosis and ruled out heart disease. Thus, Dr. Combs determined that the Miner's

restrictive lung defect along with the results from the pulmonary function test showed that Mr. Kirkling had pneumoconiosis due to coal dust exposure. He also diagnosed the Miner with a pulmonary impairment as a result of coal dust exposure and cigarette smoking. He agreed that an increase in interstitial lung markings can be caused by heart failure, obesity, and cigarette smoking. He stated that he believed that 75 percent of the Miner's COPD was due to cigarette smoking. He also opined that environmental pollutant exposure also contributed to his disease. Even if the Miner had overt interstitial x-ray markings, Dr. Combs would still opine that the Miner had a lung disease due to his occupational exposure. He based this conclusion entirely on the Miner's history. Dr. Combs is board-certified in Internal Medicine.

Dr. Pangan

Dr. I.F. Pangan examined the Miner on November 1, 1990. (DX 39-10). He noted that the Miner had 44 years of coal mine employment and smoked one-half pack of cigarettes a day for 30 years. He administered a chest x-ray and an arterial blood gas study. He diagnosed the Miner with probable emphysema, probable interstitial fibrosis based on the x-ray, and a restrictive and obstructive ventilitation impairment, which was secondary to his fibrosis.

Dr. Lenyo

Dr. Ludimere Lenyo examined the Miner on December 6, 1990 and issued a report on June 13, 1991. (DX 39-16). He considered a coal mine employment of 44 years as a surface miner and noted that the Miner smoked a pack of cigarettes a day. He administered a pulmonary function study, an arterial blood gas study, an EKG, and reviewed a chest x-ray taken on December 6, 1990. Based on his examination of the Miner and review of the chest x-ray, he diagnosed pneumoconiosis due to the inhalation of coal dust and silicone particles. Based on the pulmonary function test results, he determined that the Miner was unable to perform his previous coal mine employment. Dr. Lenyo is board-certified in Internal Medicine.

On April 30, 1992, Dr. Lenyo issued a one page report after examining the Miner during an office visit on April 10, 1992. (CX 7). He noted that Miner smoked one pack of cigarettes a day for 40 years. He diagnosed Mr. Kirkling with chronic bronchitis, interstitial lung disease, and COPD.

Dr. Lenyo was deposed on June 22, 1992. (CX 10). He stated that he has treated the Miner since June 1977 and had last treated him in June 1992. While under his care, Dr. Lenyo has examined the Miner, elicited a patient history, and performed various x-rays and other clinical testing. He diagnosed the Miner with the following: coronary artery disease, cardiac dysrhythmia, hypertension, chronic bronchitis, and chronic interstitial lung disease. In addition, in October of 1989, he diagnosed the Miner with CWP based on a chest x-ray and physical examination. He stated that based on his physical findings from his December 6, 1990 examination of the Miner, he diagnosed the Miner with emphysema and pulmonary fibrosis. He reviewed the results of three pulmonary function tests administered at his office on June 13, 1991, April 30, 1984, and December 6, 1990 and concluded that they accurately reflected Mr. Kirkling's lung function. He explained that these studies were significant because they showed a progressive decrease in the Miner's vital lung capacity. Dr. Combs interpreted these findings as being indicative of progressive scarring in the Miner's lungs from progressive fibrosis. Based on the results of his 1990 examination, he determined that the Miner had a restrictive lung disease caused by his coal mine employment history. He explained that the Miner's smoking also contributed to his lung disease.

Dr. Lenyo was also deposed regarding an exam he performed on the Miner on April 30, 1992. (CX 10). He stated that the pulmonary function test results from that date indicated that the Miner had a restrictive lung disease caused by interstitial pulmonary fibrosis. He stated that he has treated the Miner's lung disease on a chronic basis with bronchodilators and antibiotics. Taking into consideration the totality of data available to him concerning Mr. Kirkling, Dr. Lenyo opined that the Miner suffered from CWP, had a severe impairment from CWP, and was unable to perform his previous work as a miner.

Dr. Lenyo later testified that the height taken from the 1990 pulmonary function test was erroneous and could have distorted the predicted values for the test. (CX 10). However, he found that the interpretation of those numbers obtained were still valid. He also stated that the Miner's smoking history of 45 years put him at significant risk for developing emphysema, COPD, hypertension, and coronary artery disease. He admitted that obesity can cause restrictive airway disease in a person. He also admitted that the Miner's x-ray findings suggested CWP but that a conclusive determination required a lung biopsy. Finally, he explained that it is impossible to apportion

causation between cigarette smoke-induced emphysema and emphysema caused by coal dust.

On February 22, 2000, Dr. Lenyo issued a letter regarding his treatment of the Miner's respiratory condition prior to his death. (DX 27). He diagnosed the Miner with severe restrictive airway disease. He stated that he last treated the Miner on April 24, 1997 in which time, he complained of a sore throat and had trouble breathing. Upon reviewing the Miner's autopsy report, Dr. Lenyo opined that the so-called "scar carcinoma" resulted from extensive pulmonary fibrosis, which in turn was secondary to pneumoconiosis. Thus, he concluded that the Miner's pneumoconiosis ultimately resulted in the development of a mixed adenocarcinoma of the lung and produced his demise.

Dr. Repsher

Dr. Lawrence H. Repsher reviewed the Miner's medical records, including chest x-rays, pulmonary function tests, and hospital records and issued a report on July 10, 1992. (DX 40). He considered a coal mine employment history of 44 years and noted that the Miner had a smoking history of between 70 to 100 pack years. He determined that the evidence was insufficient to support a finding of CWP, any intrinsic lung disease of any kind, or a pulmonary impairment, either caused by or permanently aggravated by the Miner's employment. Dr. Repsher is board-certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine.

Dr. Repsher also reviewed the deposition testimony of Dr. Lenyo taken on June 22, 1992 and issued a supplemental report on July 10, 1992. (DX 40). He determined that Dr. Lenyo's diagnosis of chronic interstitial lung disease or CWP was irrational since the Miner's most recent x-rays were negative and the pulmonary function test results were normal. He disagreed with Dr. Lenyo's determination that the April 1984, November 1985, and December 1990 pulmonary function tests were an accurate reflection of Mr. Kirkling's lung exam. He found, based on the evidence he reviewed, that the tests showed a gross lack of cooperation and effort. He suggested that since Dr. Lenyo was not a pulmonologist, radiologist, or a B-reader, his positive x-ray interpretation reports should be given less weight. He concluded that the evidence was insufficient to support Dr. Lenyo's findings of pneumoconiosis and total disability. In addition, he believed that Dr. Lenyo's discussion of the difference between COPD and chronic bronchitis

was "medical gibberish" and that it was in direct contradiction of the medical literature.

On January 30, 1993, Dr. Repsher reviewed additional medical evidence and issued a consultative report. (DX 40). He noted that the Miner worked as a coal strip miner for 44 years and had a smoking history of 70 to 100 pack years. Based on his review of the medical data, he determined that the Miner did not have pneumoconiosis nor an intrinsic lung disease of any kind. He determined that the Miner probably had commercial exposure to asbestos, but no evidence of asbestosis. He concluded that Mr. Kirkling has never suffered from any pulmonary impairment as a result of his coal mine employment. He based his opinion on the following factors: the Miner has no chest x-ray evidence of pneumoconiosis; his effort dependent pulmonary function testing is within normal limits; and the results of his arterial blood gas tests rule out any clinically significant intrinsic lung disease.

Dr. Repsher was deposed on March 2, 1993 regarding the medical reports he issued on July 10, 1992, June 29, 1992, and January 30, 1993. (DX 40). He opined that the x-ray evidence was insufficient to diagnose CWP. He indicated that the arterial blood gas test results from November 1992 to November 1999 were all within the normal range. He explained that if Mr. Kirkling had an intrinsic lung disease, his PO2 reading would have dropped with exercise. However, since the Miner's PO2 reading improved with exercise, Dr. Repsher determined that such a reading could be attributed to cigarette smoking or being overweight. He also concluded that none of the Miner's pulmonary function tests were performed adequately for interpretation because of his poor effort or cooperation. He found that although all of the Miner's tests were invalid, his residual volume was normal, indicating no restrictive lung disease like CWP. He explained that CWP is primarily a restrictive lung disease and it gives some residual volume. In addition, although the Miner had a significant smoking history, he determined that it appears that Mr. Kirkling was not susceptible to developing a significant obstructive lung disease. He concluded that the Miner did not have any evidence of any kind of pneumoconiosis or pulmonary impairment caused by coal dust exposure.

On September 23, 1993, Dr. Repsher reviewed Dr. Combs' July 28, 1992 medical report and Dr. Marvin Rosecan's August 30, 1993 medical report and issued a report outlining his disagreements with their opinions. (DX 40). He noted that Dr. Combs

minimized the Miner's smoking history and neglected to mention Mr. Kirkling's well documented arterialsclerotic heart disease. He found that Dr. Combs' diagnosis of COPD was based on pulmonary function test results that were not valid due to the Miner's poor effort and cooperation. He also determined that Dr. Combs' diagnosis of CWP was not supported by any of the x-ray or physiologic data.

Additionally, Dr. Repsher opined that based on Dr. Rosecan's examination findings, Mr. Kirkling suffered from congestive heart failure. However, he determined that Dr. Rosecan, like Dr. Combs, failed to mention, the Miner's obesity, hypertension, heart disease, the new evidence of active ischemia, and history of prior pulmonary embolism. He also concluded that Dr. Rosecan greatly discounted the Miner's smoking history.

Dr. Repsher was deposed for a second time on January 4, 1994. (DX 40). He reiterated his findings from his written report. He determined that the pulmonary function test performed on the Miner under the supervision of Dr. Rosecan was not a true reflection of his pulmonary condition due to Mr. Kirkling's poor effort and cooperation. He based his opinion on the spirometric tracings from the test. He diagnosed the Miner with arteriosclerotic heart disease but determined that he did not have any evidence of cor pulmonale. He opined that the Miner did not have a pulmonary problem. However, he was unable to exclude a mild degree of COPD, which was likely due to his smoking history.

In addition, based on the Miner's blood gas test results, Dr. Repsher opined that Mr. Kirkling had very little, if any, intrinsic lung disease. He disagreed with Dr. Combs' assessment that 75 percent of his COPD was due to cigarette smoking. He explained that COPD does not occur in individuals who are exposed to chronic low levels of environmental pollutants. He also disagreed with Dr. Rosecan's diagnosis of restrictive lung disease because he believed that Dr. Rosecan confused the physical finding of obstructive lung disease with the diagnosis of restrictive lung disease. He also determined that although Dr. Rosecan made classic findings relating to congestive heart failure, he concluded without a rational basis that Mr. Kirkling did not have it. He found that Dr. Rosecan based his opinion on a smoking history between 20 and 25 pack years, which was substantially less than what was noted by Drs. Lenyo and Combs. He opined that Mr. Kirkling does not have coal workers' pneumoconiosis because "[CWP], when it becomes of clinical

significance and potentially disabling, is essentially a pure restrictive disease . . ..”

Dr. Howard

Dr. David W. Howard examined the Miner on June 22, 1992 and issued a report on August 4, 1992. (DX 40). He considered a coal mine employment history of 43 years and noted that the Miner was a smoker who currently smokes one-half pack of cigarettes a day but had smoked up to three packs a day in the past. He provided the Miner with a complete pulmonary examination, including a pulmonary function study, an arterial blood gas study, an EKG, and a chest x-ray. He determined that the Miner suffered from a severe obstructive airway disease caused by his tobacco use. He found no evidence of a restrictive lung disorder consistent with pneumoconiosis.

Dr. Howard was deposed on January 12, 1994. (DX 40). He diagnosed the Miner with severe obstructive airway disease, which he determined was related to tobacco abuse. He based his opinion on the notion that tobacco abuse causes an obstructive impairment and pneumoconiosis causes a restrictive impairment. He determined that the Miner did not have pneumoconiosis. He explained that the decreased breath sounds he noted were probably due to the Miner’s obesity. He also explained why Mr. Kirkling does not have a restrictive lung disease. He stated that Mr. Kirkling was totally disabled as a result of his obstructive lung disease.

Dr. Rosecan

Dr. Marvin Rosecan examined the Miner on July 30, 1993 and issued a report on August 30, 1993. (CX 18). He considered a coal mine employment history of 44 years. He provided the Miner with a complete pulmonary evaluation, including a chest x-ray, a pulmonary function test, an arterial blood gas study, and an EKG. He determined that the Miner had “clear evidence of having developed interstitial fibrosis with secondary asthmatic bronchitis and probable bronchiectasis due to [CWP].” He based his opinion on the Miner’s history of working in the coal mines, a severe restriction of his pulmonary function, and having been a mild chronic smoker for many years. He also determined that there was no evidence of congestive heart failure to account for his shortness of breath. He concluded that the Miner was totally disabled as a result of his coal mine employment history. Dr. Rosecan is board-certified in Internal Medicine.

Dr. Rosecan was deposed on November 11, 1993. (CX 22). Based on the pulmonary function test results administered on July 30, 1993, he opined that the Miner had a severe restricted pulmonary disease and some obstructive pulmonary disease. He determined that the results were a true portrayal of his pulmonary function. He also determined that the interstitial lung markings and the nodularity throughout the lung fields were compatible with pneumoconiosis and commonly silica type of dust. He based his opinion on the Miner's chest x-ray. He opined that the Miner suffered from heart disease and an enlarged heart but did not have congestive heart failure.

Based on the Miner's history, physical examination, chest x-ray, pulmonary function test, pulmonary stress test, and oxygen levels obtained during exercise and at rest, Dr. Rosecan concluded that the Miner had significant CWP. He also diagnosed the Miner with a significant respiratory and pulmonary impairment. Thus, he determined that the Miner was totally disabled. He found that the Miner's impairment was not typical of what one would see from cigarette smoking. However, he did state that smoking, obesity, and heart disease could aggravate an individual's breathing and cause shortness of breath. Additionally, although Dr. Rosecan considered a smoking history of 20 to 25 years, he determined that even if the Miner had a greater smoking history, his opinion would not change. Dr. Rosecan is board-certified in Internal Medicine.

Dr. Cook

Dr. David B. Cook examined the Miner on August 27, 1991 and issued a report on September 9, 1991. (DX 39). He noted that the Miner had 45 years of coal mine employment working on strip mines and had previously smoked one and three-fourths packs of cigarettes a day since the age of 25 but had recently cut back to one-half pack a day. He provided a full pulmonary workup, including a chest x-ray, a pulmonary function study, and an EKG. He diagnosed the Miner with an obstructive airway disease with a predominant chronic bronchitic component. He was unable to determine the cause of his disease and concluded that the chest x-ray did not indicate CWP.

Dr. Cook was deposed on July 9, 1992. (DX 40). He stated that the Miner's pulmonary function test results showed that Mr. Kirkling did not cooperate during the test. He diagnosed the Miner with chronic bronchitis, which was due to his smoking history. He determined that based on the Miner's complete evaluation, Mr. Kirkling did not have CWP or a pulmonary

limitation to exercise. However, he did diagnose the Miner with having significant cardiac disease. He also diagnosed the Miner with some level of pulmonary impairment but concluded that he was unable to determine the severity of the disease because he did not have a valid spirometry. Dr. Cook is board-certified in Critical Care and Internal Medicine and Pulmonary Disease.

Dr. Tuteur

Dr. Peter G. Tuteur reviewed the Miner's medical records and issued a consultative report on July 9, 2002. (EX 5). He noted that the Miner worked in the coal mine industry exclusively as an aboveground miner for over 40 years and had a heavy smoking history, possibly exceeding 100 pack years. He determined that although the pathologic evidence showed that the Miner had simple CWP, the disease was not severe enough to contribute to his death or produce clinical symptoms, physical abnormalities, or impairment of the pulmonary function, or radiographic changes. He diagnosed the Miner with cigarette smoke-induced COPD evidenced by both chronic bronchitis and severe emphysema, which was not caused by coal dust inhalation. He opined that the Miner died of metastatic squamous cell carcinoma originating in the larynx and metastasizing throughout the lungs, which he determined resulted from the chronic inhalation of tobacco smoke. He also believed that the Miner's cigarette smoke-induced COPD, chronic bronchitis, severe emphysema, and artery disease, which was complicated by poorly controlled hypertension, contributed to his death. Dr. Tuteur is board-certified in Internal Medicine and Pulmonary Disease. (EX 6).

Dr. Tuteur was deposed on April 21, 2003. (DX 48). He determined that although the Miner's pulmonary function tests were able to be validated, he opined that Mr. Kirkling had severe lung obstruction with no documented evidence of reversibility. He explained how he distinguished the Miner's lung disease from those caused by coal dust inhalation. He concluded that the evidence was insufficient to diagnose complicated CWP.

On September 13, 2005, Dr. Tuteur issued a supplemental report after reviewing additional medical evidence. (EX 17). He opined that the Miner had pathologically identifiable mild simple CWP. However, he concluded that pneumoconiosis played no role in the Miner's death. He determined that the Miner's cancer was the most significant problem affecting his health and that it eventually caused his death. He concluded that the

Miner's cigarette smoke-induced COPD, chronic bronchitis and emphysema, and coronary artery disease, which was complicated by poorly controlled hypertension, also contributed to his death.

Dr. Tuteur was deposed on October 20, 2005. (EX 21). Since his last deposition in 2003 and supplemental report in 2005, he reviewed the supplemental medical reports of Drs. Cohen and Green and two affidavits supporting the Miner's coal mine employment history in anticipation of the deposition. He affirmed his previous findings that the Miner had minimal simple CWP but that it did not contribute to the Miner's death. He also discussed the differences between the etiologies of focal emphysema and centrilobular emphysema and why the Miner's disease was not related to coal dust. He found Dr. Green's diagnosis of emphysema in conflict with those in the textbook Dr. Green authored in 1988. However, Dr. Tuteur did admit that he had not conducted any original research on the relationship between coal dust exposure and the development of lung disease. Dr. Tuteur stated that the critiques on which he relied of the peer reviewed articles, cited by Drs. Green and Cohen, have not been published in any peer-reviewed journal.

Dr. Renn

Dr. Joseph J. Renn, III, conducted an independent medical review of the Miner's medical records and issued a report on August 4, 2002. (EX 7). He considered a coal mine employment history of 44 years and noted a smoking history of between 15 pack years and 126 pack years. He noted that the record contained no valid spirometry studies and that the resting and exercise arterial blood gas studies revealed no interference with gas exchange. He opined that the Miner did have a mild degree of simple CWP, which he based on the findings from the pathologists' reports. He diagnosed the Miner with centrilobular and bullous emphysema and an interstitial lung disease as a result of tobacco smoking. Since the pulmonary function test results were invalid and the gas exchange from the arterial blood gas tests were normal, he opined that the Miner did not have a significant ventilatory impairment. Thus, he concluded that the Miner's death was neither caused by nor hastened by pneumoconiosis. He believed that the evidence showed that the Miner died of an upper airway hemorrhage owing to widespread local invasion of carcinoma of the larynx. He opined that the Miner's death would have occurred whether or not he had ever been exposed to coal mine dust. Dr. Renn is board-certified in Internal and Forensic Medicine and Pulmonary Disease.

Dr. Renn was deposed on March 27, 2004. (EX 12). He thoroughly explained how the hemorrhage Mr. Kirkling developed in his upper airway, as a result of treating his larynx cancer, caused his death. Although he diagnosed the Miner with emphysema, he explained that it was not focal emphysema, which is the type associated with CWP. Regarding his diagnosis of interstitial pulmonary fibrosis, he stated that it most likely resulted from tobacco smoking because of the association with respiratory bronchiolitis and interstitial lung disease. He also stated that the Miner's interstitial fibrosis explained the various positive x-ray interpretations of pneumoconiosis.

After having reviewed the May 2003 medical report of Dr. Green, Dr. Renn supplemented his March 2004 deposition testimony by way of deposition on November 12, 2004. (EX 14). He disagreed with Dr. Green's conclusion that interstitial lung disease was a component of CWP. He explained that it is impossible for Dr. Green to say with any medical certainty that the Miner's interstitial fibrosis was due to pneumoconiosis and not his age or tobacco smoking since the disease was not in proximity to the coal macules he found. He also disagreed with the articles Dr. Green cited in his report to support the proposition that interstitial fibrosis is a form of CWP. He stated that the articles were questionable because "most" of the articles did not control for tobacco smoking or the effects of aging.

Dr. Renn also provided a detailed explanation as to why he believed pneumoconiosis did not contribute to the Miner's death. Specifically, he stated that all of the pathologists who reviewed the autopsy slides, except for Dr. Green, determined that the Miner only had a mild form of CWP. Secondly, although the Miner's ventilatory function tests were not valid, based on his FEV1 from his July 1993 test, he should have lived until 2006. Finally, he died because of a massive hemorrhage as a result of his larynx cancer. Therefore, despite what his lung function was, the Miner would have died due to the massive amounts of blood pouring into his lungs and upper airway.

On September 19, 2005, Dr. Renn issued a supplemental report after reviewing additional medical evidence. (EX 17). He determined that the records did not alter his previous opinions contained in his August 2002 medical report.

Dr. Rosenberg

Dr. David M. Rosenberg conducted an independent review of the Miner's medical report and issued a report on February 24, 2003. (EX 9). He considered a coal mine employment history of 43 years and seven months in which all his work was performed on the surface of the mine. He noted that the Miner had a smoking history of 100 pack years and that he smoked throughout his lifetime. He determined that the majority of the x-ray evidence demonstrated that Mr. Kirkling did not have CWP. He explained that the nodules present on the x-rays were related to metastatic laryngeal carcinoma. Additionally, he found that the Miner had normal gas exchange on exercise and that the rales heard on examination can be explained by a component of congestive heart failure or the diffuse fibrotic abnormalities noted at the time of autopsy.

Although the Miner's pulmonary function measurements were invalid, Dr. Rosenberg determined that an indirect assessment of the Miner's "FRC" measurements, which are effort-independent, showed that he had an obstructive lung disease. He found that the lack of oxygenation abnormalities upon exercise showed that the Miner did not have a disabling respiratory condition secondary to his intrinsic lung disease. He opined that since the Miner had, at the worst, the most minimal form of simple CWP without nodular formation, his extensive emphysema and obstructive lung disease could not be related to coal dust exposure. He explained that "emphysema associated with coal mine dust exposure begins with the coal macule centered around the terminal bronchioles, becoming more extensive as nodular CWP progresses." He opined that the Miner's obstructive lung disease and emphysema was due to his smoking history. He suggested that the Miner had multiple disabling conditions, including morbid obesity, atherosclerotic heart disease, hypertension, and carcinoma. Dr. Rosenberg determined that the Miner's laryngeal carcinoma, which was due to his smoking history, eventually caused his death. He opined that the cancer was not related to or caused by the inhalation of coal dust.

After reviewing the May 2003 medical report of Dr. Green, Dr. Rosenberg was deposed on November 4, 2004 regarding the medical report he issued in February 2003. (EX 15). He determined that the Miner "possibly" had a mild degree of simple CWP, which he based on the pathology evidence. He also determined that the Miner had extensive emphysema, which ranged from centrolobular emphysema to panlobular emphysema. He stated that since the emphysema was not focal emphysema, it was not

related to coal dust exposure. He opined that the Miner's arterial blood gas test results showed that he did not have any significant interstitial lung disease, be it CWP or idiopathic pulmonary fibrosis. He noted that although there were articles that suggested centrolobualr and panlobular emphysema were related to coal dust exposure, he determined that those articles did not control for cigarette smoking, "for the most part." Dr. Rosenberg disagreed with Dr. Green's conclusion that interstitial fibrosis or linear types of fibrosis were related to coal dust exposure. He stated that the articles that Dr. Green cited in his report were questionable because they did not control for smokers. He also explained why he disagreed with Dr. Green's conclusion that smoking does not causes interstitial lung disease.

On September 30, 2005, Dr. Rosenberg issued a supplemental report after reviewing additional medical evidence. (EX 19). He continued to diagnose the Miner with a minimal degree of simple CWP but determined it was not severe enough to cause a respiratory impairment or contribute to his death. He also opined that the Miner's emphysema was due to smoking and not coal dust because it was not focal emphysema in association with the coal macule. He noted that the Miner's death was due to his advanced metastatic squamous cell carcinoma of the larynx, which spread to his lungs.

Dr. Rosenberg was deposed on October 18, 2005. (EX 20). Since his last deposition in 2004 and supplemental report in 2005, he reviewed the supplemental medical reports of Drs. Cohen and Green in anticipation of the deposition. He reiterated that despite the Miner's lung condition, he would have died when he did as a result of the laryngeal cancer. Based on the additional medical evidence he reviewed, he concluded that the Miner did not have complicated CWP or cor pulmonale with right sided congestive heart failure. Additionally, he stated that since all of the Miner's pulmonary function tests were invalid, he was unable to determine if the Miner had a restrictive lung disease. He also explained why there was no credible evidence to support the proposition that coal mine dust exposure and smoking cause equal drops in the FEV1 value. He also stated that there were no pathologic models to demonstrate that the inhalation of coal dust caused the diffuse interstitial pattern found in the Miner's lungs. He explained that the pathologic response to coal dust is macule formation, leading to nodular formation.

Dr. Cohen

Dr. Robert A.C. Cohen reviewed the Miner's medical records and issued a consultative report on October 2, 2005. (CX 29). He noted that the Miner had a 40 plus year coal mine employment history in strip mining and that he had a smoking history of between 40 to 80 pack years. Based on the medical data he reviewed, he opined that the Miner did suffer from CWP and that his chronic respiratory condition was substantially related to his coal mine employment history. He based his opinion on the following: the Miner's coal mine employment history; symptoms and physical examinations findings of chronic lung disease noted by several examiners; significant positive x-ray evidence of CWP; and the autopsy evidence that revealed CWP and moderate to severe emphysema. He also gave great credence to Dr. Green's findings as he is an internationally renowned occupational pulmonary pathologist. He determined that the Miner's emphysema was caused by his smoking and coal mine employment.

Dr. Cohen also opined that the Miner's death was due to his exposure to coal dust. He determined that the Miner "died a respiratory death from the combined effects of hemorrhage from cancer of the larynx, metastatic cancer, pulmonary emboli, severe emphysema, pneumoconiosis which was both macular lesions and interstitial fibrosis." He determined that these conditions hastened the Miner's death. He disagreed with Dr. Renn's opinion that the Miner's respiratory disease was unrelated to his death, since he died of a massive hemorrhage. He explained that if the Miner would not have had his interstitial lung disease and severe emphysema, Mr. Kirkling's lungs would have been in better condition to withstand the effects of hemorrhage, pulmonary emboli, and metastatic cancer. He also determined that Drs. Tomashefski, Hutchen, and Renn's diagnoses of pulmonary fibrosis with unknown causes are not reasoned since the Miner had 43 years of exposure to a substance which is well known to cause lung scarring. Finally, he offered a detailed explanation discounting Dr. Rosenberg's opinion that the Miner's centrilobular emphysema was not related to coal dust exposure. Dr. Cohen is board-certified in Internal Medicine and Pulmonary Disease.

Hospital and Treatment Records

The record contains nine pages of handwritten treatment records dating from November 6, 1985 to January 3, 1991. (DX 39, pp. 35-43). It is unclear from the record where these notes

originated and if they relate to the Miner's pulmonary impairment as they are completely illegible.

The record also contains 13 pages of Dr. Paul D. Righi's progress notes dated April 21, 1998 to December 22, 1998. (DX 29). These notes show that Dr. Righi diagnosed and treated the Miner for throat cancer but contained no discussion of whether the Miner had pneumoconiosis.

The record also contains the Miner's treatment records from Union Hospital dating from July 12, 1981 to October 1989. (DX 40; *see* JX 1). I find the handwritten portion of these notes to be mostly illegible and the quality of some of the copies to be very poor. These records show that the Miner was admitted through the Emergency Room for chest pains on multiple occasions. Multiple arterial blood gas tests were administered to the Miner on July 12 and 13, 1981. The tests were all non-qualifying.

DISCUSSION AND APPLICABLE LAW

Claimant filed her survivor's claim for benefits on April 2, 2002. Entitlement to benefits must be established under the criteria at Part 718. Section 718.205(a) provides that a survivor is eligible for benefits if the miner's death was due to pneumoconiosis. Initially, the administrative law judge must determine if the evidence demonstrates that the miner suffered from pneumoconiosis and that the miner's pneumoconiosis arose out of coal mine employment. *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993). A claimant's failure to establish by a preponderance of the evidence that the miner had pneumoconiosis, that the miner's pneumoconiosis arose out of coal mine employment and that the miner's death was due to pneumoconiosis precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-112 (1989). However, the Board has held that, in a survivor's claim under Part 718, the administrative law judge must make a threshold determination as to the existence of pneumoconiosis under 20 C.F.R. § 718.202(a) prior to considering whether the miner's death was due to pneumoconiosis. *Trumbo, supra.*

Pneumoconiosis and Causation

On brief, Claimant argues that Employer is precluded from re-litigating the issue of pneumoconiosis since it was established in the Miner's claim. To support this proposition, Claimant cites *Zeigler Coal Co. v. Director, OWCP [Villain],* 312

F.3d 332 (7th Cir. 2002). Claimant asserts that the "only exception to this doctrine of claim preclusion is where an autopsy has been performed since the [Miner's] decision on the presence of CWP was made and the coal company uses the autopsy to argue that, in fact, the miner never had pneumoconiosis." (Claimant's Brief at 13). Here, since the autopsy prosector diagnosed the Miner with CWP, Claimant contends that Employer should be collaterally estopped from re-litigating the existence of CWP in the survivor's claim.

In *Villian,* the court noted that "[both] a mine operator and a survivor are allowed to introduce autopsy evidence in an effort to show that the determination made during the miner's life was incorrect." 312 F.3d at 334. Here, an autopsy was performed and the Employer has presented evidence in an effort to refute an earlier finding of pneumoconiosis. Additionally, although the autopsy prosector diagnosed the Miner with CWP, Employer submitted the medical reports of Drs. Naeye and Tomashefski, who opined that the autopsy evidence was insufficient to establish CWP. In the Seventh Circuit, it is an error to accord more weight to a prosector's opinion over the opinion of a reviewing pathologist. *Peabody Coal Co. v. McCandless,* 255 F.3d 465 (7th Cir. 2001). Therefore, I find that Employer is not collaterally estopped from re-litigating the existence of pneumoconiosis in the survivor's claim.

Under the Act, "'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. In evaluating the x-ray evidence, I assign heightened weight to interpretations of physicians who qualify as either a board-certified radiologist or "B" reader. *See Dixon v. North Camp Coal Co.*, 8 BLR 1-344, 1-345 (1985). I assign greatest weight to interpretations of physicians with both of these qualifications. *See Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993); *Sheckler v. Clinchfield Coal Co.*, 7 BLR 1-128, 1-131 (1984). Because pneumoconiosis is a progressive disease, I also may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *See Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149, 1-154 (1989) (en banc); *Casella v. Kaiser Steel Corp.*, 9 BLR 1-131, 1-135 (1986).

The evidence of record contains 57 interpretations of nine chest x-rays. Out of the 57 readings, 37 were negative for pneumoconiosis, 17 were positive, and three were determined to be unreadable. The x-ray interpretations of April 1986, November 1988, November 1990, December 1990, and September 1994 were read as negative by all of the readers. Therefore, these x-rays do not establish pneumoconiosis.

The June 1992 x-ray was read as positive by a physician with no radiological qualifications and negative by physicians who were both board-certified radiologists and B-readers. I give more weight to the interpretations of physicians who are dually qualified. Therefore, I find that the June 1992 x-ray does not establish pneumoconiosis.

The x-rays dated August 1991, April 1992, and July 1993 were determined to be positive and negative for pneumoconiosis by physicians who were both board-certified radiologists and B-readers. In *Director, OWCP v. Greenwich Collieries, et al.*, 114 S.Ct. 2251 (1994), the U.S. Supreme Court held that where the evidence is equally probative, the claimant necessarily fails to satisfy his burden of proving the existence of pneumoconiosis by a preponderance of the evidence. As such, I find the x-ray readings dated August 1991, April 1992, and July 1993 to be equivocal.

Therefore, in weighing all of the x-ray evidence, I find that Claimant has failed to establish pneumoconiosis under Section 718.202(a)(1).

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy and autopsy evidence. A report of an autopsy submitted in connection with a claim shall include a detailed gross macroscopic description and microscopic description of the lungs or visualized portion of the lung. § 718.106(a). A finding in an autopsy of anthracotic pigmentation shall not be sufficient, by itself, to establish the existence of pneumoconiosis. § 718.202(a)(2). Autopsy evidence is the most reliable evidence of the existence of pneumoconiosis. *Terlip v. Director, OWCP*, 8 B.L.R. 1-363 (1985).

The record contains the autopsy prosector's report and the reports of six pathologists who reviewed the autopsy slides and report. (JX 1). Although the parties listed Dr. Katzman's report under the Section of "Pathology Evidence" in the Joint Stipulation, Dr. Katzman is not a pathologist and he did not review the autopsy slides. Therefore, I will consider his

opinion under Section 718.202(a)(4) with other examining and consultative reports.

Dr. Heidingsfelder performed the Miner's autopsy and diagnosed him with simple coal miner's pneumoconiosis. His report included both a detailed gross and microscopic description of the lungs. On the microscopic examination of the Miner's lung tissue, he noted that there were "anthracotic-fibrotic lesions with localized emphysema" and "pulmonary anthracosis." Clinical pneumoconiosis consists of "permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment." 20 C.F.R. § 718.201(a)(1)(2004). As Dr. Heidingsfelder sufficiently described his findings in light of his diagnoses, I find his opinion to be well reasoned and documented. Thus, his opinion is entitled to full probative weight.

Drs. Caffrey, Hutchins, Green, and Oesterling all reviewed the autopsy evidence and diagnosed the Miner with simple CWP. These four physicians provided reports that set forth their pathologic findings and observations, and their findings were supported by adequate pathology evidence. Therefore, I find the opinions of Drs. Caffrey, Hutchins, Green, and Oesterling to be well reasoned and documented. As such, I assign their opinions full probative weight.

Drs. Naeye and Tomashefski were the only two pathologists who determined that the Miner did not have CWP. Dr. Naeye found anthracotic macules within a large mass of fibrous tissue but found no birefringent crystals and noted that focal emphysema may or may not be associated with the black deposits. Dr. Caffrey found black pigment and one coal macule in the Miner's lung but determined that one coal macule was not enough to support a diagnosis of CWP.

However, I give less weight to the opinions of Drs. Naeye and Tomashefski because their conclusions are completely contrary to the findings of the other very qualified pathologists who diagnosed the Miner with CWP. Additionally, as both doctors observed findings compatible with a diagnosis of CWP but did not diagnose the disease, I find their final conclusions concerning the existence of CWP to be inconsistent with their pathological findings. A report may be given little weight where it is internally inconsistent and inadequately reasoned. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986).

Therefore, I assign Drs. Naeye and Tomashefshi's opinion less probative weight.

In sum, I find the opinions of Drs. Heidingsfelder, Caffrey, Hutchins, Green, and Oesterling outweigh the opinions of Drs. Naeye and Tomashefski. Additionally, although Employer contested the issue of pneumoconiosis at the hearing, it appears from its brief that they may have conceded the issue. Specifically, Employer states that: "At most[,] the findings of very mild and minimal CWP is present; at most[,] Dr. Green finds simple CWP, but no one found any significant degree of pneumoconiosis nor any complicated pneumoconiosis." (Employer's Brief at 52). Therefore, for the reasons stated above, I find that Claimant has established pneumoconiosis by a preponderance of the evidence pursuant to Section 718.202(a)(2).

Causation of Pneumoconiosis

Once pneumoconiosis has been established, the burden is upon the Claimant to demonstrate by a preponderance of the evidence that the pneumoconiosis arose out of the miner's coal mine employment. 20 C.F.R. § 718.203(b) (2004) provides:

> If a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment.

I have found that Mr. Kirkling was a coal miner for 42 years, and that he had pneumoconiosis. Claimant is entitled to the presumption that the Miner's pneumoconiosis arose out of his employment in the coal mines. No physician opining as to the presence of pneumoconiosis offers an alternative cause to rebut this presumption. See, *Smith v. Director, OWCP,* 12 BLR 1-156 (1989). Therefore, I find that the Miner's pneumoconiosis arose from his coal mine employment.

Death Due to Pneumoconiosis

Claimant is entitled to benefits as the Miner's survivor if she demonstrates that his death was due to pneumoconiosis. 30 U.S.C. § 901(a); 20 C.F.R. § 718.205(a). Section 718.205(c) provides that:

> For the purpose of adjudicating survivors' claims filed on or after January 1, 1982, death will be

considered to be due to pneumoconiosis if any of the following criteria is met:

1. Where competent medical evidence establishes that the miner's death was due to pneumoconiosis, or

2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or

3. Where the presumption set forth at §718.304 is applicable.

4. However, survivors are not eligible for benefits where the miner's death was caused by traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless pneumoconiosis was a substantially contributing cause of death.

20 C.F.R. § 718.205(c)(2004).

The United States Court of Appeals for the Seventh Circuit, within whose jurisdiction the instant case arises, has held that pneumoconiosis will be considered a substantially contributing cause of the miner's death if it actually hastened the miner's death, even if only briefly. *Zeigler Coal Co.*, 312 F.2d at 334; *Peabody Coal Co. v. Director, OWCP [Railey]*, 972 F.2d 178, 16 BLR 2-121 (7th Cir. 1992). This interpretation means that any acceleration of the miner's death that is attributable to pneumoconiosis will entitle Claimant to benefits. *See Peabody Coal Co.*, 49 F.3d at 183.

Claimant has the burden of demonstrating by a preponderance of the evidence that pneumoconiosis was a substantially contributing cause of the Miner's death. The Supreme Court of the United States relates the term "preponderance of the evidence," to "the degree of proof which must be adduced by the proponent of a rule or order to carry its burden of persuasion in an administrative proceeding." See, *Steadman v. SEC*, 450 U.S. 91, 101 S.Ct. 999 (1981). If that degree is a preponderance, then the initial trier of fact must believe that it is more likely than not that the evidence establishes the proposition in question. *Id.*

The Miner died on January 17, 1999. (DX 7). The numerous medical records relating to treatment while the Miner was living do not contain a discussion of whether the Miner's death was due to pneumoconiosis. The record establishes that the medical reports and/or deposition transcripts of Drs. Combs, Pangan, Repsher, Howard, Rosecan, and Cook were all prepared prior to 1995, which is years before the Miner's death. Although these records show that the Miner was diagnosed with pneumoconiosis, this evidence is not probative as to whether the Miner' death was due to the disease. A physician's report, which is silent as to a particular issue, is not probative of that issue. *See Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000). In fact, neither party on brief made factual findings nor did they present any legal discussion concerning the applicability of these records to the death causation issue. As such, I find that the medical reports of Drs. Combs, Pangan, Repsher, Howard, Rosecan, and Cook are non-probative regarding the death causation issue.

Additionally, I find that the Miner's hospital records and treatment notes are also non-probative regarding the cause of the Miner's death. These records also pre-date the Miner's death and fail to address any medical conditions impacting the death causation issue. Neither party on brief made factual findings nor offered any legal analysis concerning this record evidence. *Id.* Therefore, the parties acknowledge and I find that this medical evidence does not support a finding that the Miner's death was due to pneumoconiosis.

The record contains a Certificate of Death, which listed the primary causes of death as hemorrhage, cancer of the larynx, occupational exposure to carcinogens, Black Lung disease, and tobacco use. The Certificate contains no other representations as to the cause of death.

Regardless, a Death Certificate, in and of itself, is an unreliable report of the miner's condition where the record provides no indication that the individual signing the Death Certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death. *Smith v. Camco Mining, Inc.*, 13 B.L.R. 1-17 (1989); *Addison v. Director, OWCP*, 11 B.L.R. 1-68 (1988). A Death Certificate that states a cause of death without some further explanation cannot be viewed as a reasoned diagnosis. *See Lango v. Director, OWCP,* 104 F.3d 573 (3rd Cir. 1997).

The Death Certificate was signed by Dr. Phillipson. However, it is unclear from the record as to whether Dr. Phillipson had knowledge of the Miner's physical condition to properly assess the cause of death or whether he had the relevant qualifications to make such a determination. Additionally, as the Death Certificate states pneumoconiosis without explaining how the diagnosis was reached or contributed to the Miner's death, I find Dr. Phillipson's opinion to be unreasoned and entitled to less probative weight. *Id.*

Dr. Heidingsfelder opined that the black lung disease noted during his post mortem examination was a contributing factor to the cause and timing of Mr. Kirkling's death. In his March 2000 letter, he indicated that he reviewed the Miner's Death Certificate and "additional clinical information provided in a letter by Dr. Lenyo to Claims Examiner dated February 22, 2000 ...." (DX 27). However, he failed to cite the specific documents that aided his conclusion or the basis for his opinion. An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984). A report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis. See *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 1983. An unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1986)(en banc). Additionally, it is also unclear from Dr. Heidingsfelder's opinion on whether he considered an accurate smoking and coal mine employment history. It is proper to discredit a medial opinion based on an inaccurate length of coal mine employment or smoking history. *See Worhanch v. Director, OWCP,* 17 B.L.R. 1-105 (1993); *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993). Therefore, I assign Dr. Heidingsfelder's unreasoned opinion little probative weight.

In November of 1999, Dr. Katzman diagnosed the Miner with CWP and with a severe restrictive lung disease. He determined that both conditions caused Mr. Kirkling's death. In May 2000, approximately six months later and after reviewing additional medical evidence, he diagnosed the Miner with CWP, emphysema, cancer of the larynx, and interstitial fibrosis. He attributed the Miner's emphysema and cancer of the larynx to cigarette smoking. He determined that CWP did not cause, aggravate, or accelerate the Miner's death. Although he noted that he relied on the opinion of Dr. Hutchins to rule out CWP as a cause of the Miner's death, he failed to explain how he reached that conclusion. A report is properly discredited where the

physician does not explain how underlying documentation supports his or her diagnosis. See *Smith, supra; Duke, supra.*

Additionally, it is proper to accord little probative value to a physician's opinion which is inconsistent with his or her earlier report or testimony. *Hopton v. U.S. Steel Corp.*, 7 B.L.R. 1-12 (1984). Dr. Katzman's failure to explain the inconsistencies between the two reports where he found death due to CWP in an earlier report and then, without explanation, found no death to CWP in a report issued approximately six months later renders his conclusions of little probative value. *See Surma v. Rochester & Pittsburgh Coal Co.*, 6 B.L.R. 1-799 (1984). Therefore, for the reasons indicated, I assign Dr. Katzman's opinion little probative weight.

Dr. Caffrey opined that cancer caused the Miner's death. Although he diagnosed the Miner with CWP, he determined that the disease was too mild to have any deleterious effect on Mr. Kirkling's lungs or hasten his death. He also diagnosed the Miner with both panlobular and centrilobualr emphysema but related it to his smoking history. He ruled out coal dust as a cause of the Miner's emphysema based on the amount of coal dust or the lack of nodule lesions on the autopsy slides he reviewed. (EX 16 at 23-4).

Claimant argues that Dr. Caffrey's view is directly "at odds with DOL and NIOSH, which have found that coal dust-induced emphysema can occur with or without the presence of medical CWP." (Claimant's Brief at 34-5). The DOL considered the relationship between smoking and coal dust exposure and emphysema prior to implementing the new regulations in 2001. Specifically, the DOL determined that the medical literature showed that clinically significant emphysema does exist in coal miners without a history of progressive massive fibrosis. 65 *Federal Register* 79941-42 (Dec. 20, 2000). Additionally, it was also determined that "[the] severity of emphysema was related to the amount of dust in the lungs." *Id.*

Here, Dr. Caffrey determined that the Miner's emphysema was solely due to cigarette smoking because of the minimal amount of coal dust and lack of nodule lesions in the Miner lungs. However, in his medical report, he diagnosed the Miner with the following: "Moderate amount of anthracotic pigment with micronodules identified in hilar lymph nodes." (DX 17). Thus, I find his deposition testimony to contradict the autopsy findings in his written report. Specifically, I find Dr. Caffrey's diagnosis of "moderate" anthracotic pigment to

contradict his deposition testimony that the amount of coal dust in the Miner's lungs was insufficient to have contributed to his emphysema. Therefore, without a more thorough explanation, I find his reasoning for ruling out coal dust exposure as a cause of the Miner's emphysema to be inconsistent with what has been accepted by the DOL. As such, I assign Dr. Caffrey's opinion less probative weight.

Dr. Oesterling diagnosed the Miner with simple CWP and emphysema but determined that the Miner's death was not due to the diseases. He concluded that the Miner's "death has resulted from metastatic squamous cell carcinoma from the upper aerodigestive tract complicated by moderately severe centrilobular, panlobular and bullous emphysema, both the result of his extensive smoking history." (EX 1). He contributed the Miner's larynx cancer to cigarette smoking and alcohol abuse.

Claimant argues that Dr. Oesterling failed to explain how he ruled out coal dust as a contributing factor to the Miner's emphysema. (Claimant's Brief at 34-5). However, I find that Claimant's argument lacks merit. On page four of Dr. Oesterling's medical report, he explained that as there was no coal dust in the emphysema fields, he directly attributed the disease to cigarette smoking. (EX 1).

Claimant also asserts that Dr. Oesterling failed to adequately explain why the Miner's lung disease was not related to coal dust exposure. (Claimant's Brief at 35). Dr. Oesterling determined that based on the level of change in the Miner's lung tissue, the Miner's history of working in the coal mines could not have caused the disease. He opined that the fibrous tissue with limited degree of black "pigment has not produced the extensive reactive change within this gentleman's pleura." (EX 1 at 2). However, Dr. Oesterling's lack of explanation on how these conclusions were reached makes his report incomplete. A report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis. *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983). As Dr. Oesterling failed to explain how coal dust was incapable of producing the severity of the Miner's lung disease, his opinion cannot be fully credited. Therefore, for the reasons indicated, Dr. Oesterling's opinion is entitled to less probative weight.

Dr. Tomashefski opined that the Miner's death was mainly due to metastatic squamous carcinoma of the larynx but that severe emphysema and interstitial fibrosis also contributed to

his death. He determined that even if the Miner had simple CWP, it would not have been sufficient to have contributed to his death. He provided a detailed explanation on why the Miner's interstitial fibrosis was not related to his coal dust exposure. (EX 11 at 15-7). However, he failed to discuss how he ruled out coal dust exposure as a cause of the Miner's emphysema. I find Dr. Tomashefski's lack of explanation makes his conclusion unsupported and, therefore, entitled to less probative weight. *See Dukes, supra.*

Dr. Hutchins diagnosed the Miner with simple CWP but determined that neither coal dust exposure nor CWP hastened his death. He opined that the Miner's pulmonary problems and death were due to his emphysema, cancer, and interstitial fibrosis. He attributed the Miner's emphysema and cancer to cigarette smoking. Although he determined that the Miner's death was not due to CWP, he failed to provide a basis for that conclusion. Additionally, he determined that the Miner's interstitial fibrosis was of an unknown origin and that his emphysema was due solely to cigarette smoking without discussing how he ruled out coal dust exposure as the cause of these diseases. A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182 (1984). As it is unclear how Dr. Hutchins ruled out coal dust exposure as a contributing factor to his death, I assign his opinion less probative weight.

Dr. Green opined that the Miner died from a number of factors, including metastatic laryngeal carcinoma, severe emphysema, and pneumoconiosis. He determined that the Miner's interstitial fibrosis was a form of CWP and explained why the disease was not a form of IPF but was related to coal dust exposure. To support this proposition, Dr. Green listed several articles to bolster his assertion that interstitial fibrosis was a form of pneumoconiosis. (DX 46 at 7). Drs. Renn and Rosenberg argue that the articles Dr. Green cited are "questionable" because they did not control for cigarette smoking or aging. However, neither doctor provided examples of statistically sound epidemiologic studies or cite to medical literature refuting Dr. Green's opinion. *See Zeigler Coal Co.*, 312 F.3d at 336. "An expert who supplies nothing but a bottom line supplies nothing of value to the judicial process." *Id.*, *quoting Mid-State Fertilizer Co. v. Exchange National Bank*, 877 F.2d 1333, 1339 (7th Cir. 1989).

Dr. Green also determined that Mr. Kirkling's emphysema was due to smoking and coal dust exposure. He explained that recent

medical literature all suggests that occupational dust causes emphysema in the approximate identical number of cases that cigarette smoke causes smoke-induced emphysema, in that both cause a breakdown of the lung connective tissue. He attributed the Miner's cancer solely to cigarette smoking. Finally, Dr. Green found no evidence that a massive hemorrhage contributed to the Miner's death. Specifically, he found no evidence of hemorrhage in the Miner's lungs or airways based on his review of the autopsy slides. I find Dr. Green's opinion to be detailed, well documented and reasoned. As such, I assign his opinion full probative weight.

Dr. Lenyo reviewed the Miner's autopsy report and determined that the Miner's pneumoconiosis developed into a mixed adenocarcinona of the lungs and produced his demise. However, I find his opinion cannot be fully credited. *See Zeigler,* 312 F.3d at 335. He did not cite to a single article in the medical literature to support his opinion, did not point to epidemiologic studies, nor did he discuss whether the Miner's significant smoking history may have contributed to his lung disease. *Id.* at 336. "An expert who supplies nothing but a bottom line supplies nothing of value to the judicial process." *Id.,* (*quoting Mid-State Fertilizer Co. v. Exchange National Bank,* 877 F.2d 1333, 1339 (7th Cir. 1989)). As such, I find Dr. Lenyo's opinion to be not well-documented and reasoned and, therefore, entitled to less probative weight. Additionally, although the record establishes that Dr. Lenyo treated the Miner from 1977 to 1997, his opinion is not entitled to any additional weight for the reasons indicated.[6]

Dr. Tuteur reviewed the Miner's medical records and opined that he died of cancer but that his cigarette smoke-induced COPD, which includes both chronic bronchitis and emphysema, and coronary artery disease also contributed to his death. However, Claimant argues that Dr. Tuteur relied on "bad science" when he determined that the Miner's lung obstruction was due solely to cigarette smoking. Dr. Tuteur found that coal-induced obstruction occurs in only about 1% of non-smoking miners,

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[6] In *Peabody Coal Co. v. McCandless*, 255 F.3d 465 (7th Cir. 2001), the Seven Circuit decided that it could be "irrational" to accord greater weight to the opinion of a treating physician. The court stated:

> Treating physicians often succumb to the temptation to accommodate their patients (and their survivors) at the expense of third parties such as insurers, which implies attaching a discount rather than a preference to their views.

whereas cigarette-induced obstruction occurs in over 20% of smokers. (EX 21 at 42-9). He believed that since obstruction occurs less frequently in non-smoking miners, Mr. Kirkling's lung disease must have reasonably resulted from cigarette smoking. Additionally, he also determined that the studies addressing whether the inhalation of coal dust produces a measurable obstructive abnormality were "substantially flawed." (*Id.*).

However, the DOL have concluded the following:

> the incidence of [non-smoking] coal miners with intermediate dust exposure developing moderate obstruction . . . is roughly equal to the incidence of moderate obstruction in smokers with no mining exposure . . . Similarly, the incidence of non-smoking miners with intermediate exposure developing severe airways obstruction . . . is equal to the incidence of severe obstruction in non-mining smokers . . . The message from the Marine study is unequivocal: Even in the absence of smoking, coal mine dust exposure is clearly associated with clinically significant airways obstruction and chronic bronchitis. The risk is additive with cigarette smoking.

Id. at 79940.

Therefore, I find Dr. Tuteur's reasoning for ruling out coal dust as a cause of the Miner's lung obstruction to be divergent from what has been found acceptable by the DOL. As such, I assign his opinion less probative weight.

Drs. Renn and Rosenberg both conducted an independent review of the medical evidence and determined that the Miner's laryngeal carcinoma, which was due to smoking, caused his death. They both diagnosed the Miner with a minimal or mild degree of simple CWP but determined that it was not severe enough to hasten his death. Each also diagnosed the Miner with centrilobular emphysema but opined that since it was not focal emphysema, it was not related to coal dust exposure. Specifically, Dr. Rosenberg explained that "[one] doesn't see the central lobular (sic) emphysema or pan lobular (sic) emphysema that can occur in individuals without associated micronodular and macronodular disease in this type of emphysema. In other words, if this type of emphysema occurs without the medical form of CWP, we're not talking about a legal form of CWP." (EX 20 at 25). Thus, I interpret Dr. Rosenberg's

statement to say that coal dust related emphysema, legal pneumoconiosis, does not occur in the absence of clinical pneumoconiosis. However, this view has been found to be "not in accord with the prevailing view of the medical community or the substantial weight of the medical and scientific literature." 65 *Federal Register* at 79939. Specifically, the DOL determined that "[m]ost evidence to date indicates that exposure to coal mine dust can cause chronic airflow limitation in life and emphysema at autopsy, and this may occur independently of CWP . . .." *Id.* As Dr. Rosenberg's views are divergent from what has been found acceptable by DOL, I find his opinion not well reasoned.

Additionally, I also find Drs. Rosenberg and Renn's views that centrilobular emphysema is not related to coal dust exposure to be divergent from those which were also found to be acceptable by the DOL. Specifically, the DOL found that the medical literature showed that "[c]entrilobular emphysema (the predominant type observed) was significantly more common among the coal workers. The severity of the emphysema was related to the amount of dust in the lungs. These findings held even after controlling for age and smoking habits." *Id.* at 79941. Thus, I conclude that Drs. Renn and Rosenberg's medical opinions relating to their emphysema diagnosis are not well reasoned and, therefore, are entitled to less probative weight.

Dr. Cohen conducted an extensive review of the Miner's medical records and determined that Mr. Kirkling died from the combined effects of hemorrhage from cancer of the larynx, metastatic cancer, pulmonary emboli, severe emphysema, and pneumoconiosis, which was both macular lesions and interstitial fibrosis. He determined that the Miner's emphysema was due to smoking and coal mine employment. He provided a detailed explanation regarding the link between obstructive lung disease and coal dust exposure, which he believes refutes the notion that coal dust exposure only produces the classic restrictive pattern of lung disease. He also determined that the Miner's interstitial fibrosis was related to coal/silica exposure. He based his opinion primarily on Dr. Green's opinion regarding the etiology of the disease.

On brief, Employer asserts that Dr. Cohen's opinion is not entitled to full probative weight as he failed to tender evidence establishing how pneumoconiosis actually hastened the Miner's death. (Employer's Brief at 58). However, I disagree. "[W]hen promulgating § 718.205(c)(5), the proposition that persons weakened by pneumoconiosis may expire quicker from other

diseases is a medical point, with some empirical support." *Zeigler Coal Co.,* 312 F.3d at 335 (*citing* 65 Fed.Reg. at 79,950). Whether this is true of Mr. Kirkling's death is a question that depends on Dr. Cohen's knowledge of the Miner's physical and mental health prior to his death.

Here, Dr. Cohen determined that "Mr. Kirkling died from the combined effects of hemorrhage, pulmonary emboli, metastatic cancer, severe emphysema, and interstitial lung disease. Had he not had the two latter processes (which had an occupational contribution to their cause) his lungs would have been better able to withstand the effects of the first three." (EX 29 at 18). Although Dr. Cohen determined that the Miner's lungs would have been better able to withstand the effects of the hemorrhage, pulmonary emboli, and metastatic cancer, he failed to explain how pneumoconiosis weakened the Miner's lungs to cause his death to occur sooner in light of his other conditions. Thus, without this explanation, I find his opinion to be not well documented and entitled to less probative weight.

In weighing these reports, I give the most weight to the opinion of Dr. Green. He is a highly qualified pathologist who provided a well-documented and reasoned opinion, which sufficiently explained his diagnoses in light of his findings. Considering all the relevant factors for crediting and discrediting a physician's medical opinion, I find that the weight of the evidence supports a finding that Mr. Kirkling died as a result of multiple and recurrent pulmonary diseases, but that his death was hastened by his underlying pneumoconiosis.

Accordingly, I find that the weight of the medical evidence demonstrates by a preponderance of the evidence that Mr. Kirkling's death was due to pneumoconiosis, as defined in § 718.205.

ENTITLEMENT

By reason of the foregoing, it is concluded that Erma Kirkling is entitled to benefits. Section 725.503(c) provides as follows:

> Benefits are payable to a survivor who is entitled beginning with the month of the miner's death, or January 1, 1974, whichever is later.

20 C.F.R. Section 725.503(c)(2004). *See Mihalek v. Director, OWCP*, 9 BLR 1-157 (1986). The Miner died on January 17, 1999. Therefore, Claimant is entitled to benefits commencing on January 1, 1999.

ORDER

Peabody Coal Company is ordered to pay:

To Claimant, Erma Kirkling, all benefits to which she is entitled under the Act commencing January 1, 1999.

ATTORNEY'S FEES

An award of attorney's fees for services to the Claimant has not been made in this Decision since no application has been filed by counsel. Claimant's counsel will have fifteen (15) days from the date of receipt of a final Order following the exhaustion of all appeals within which to submit a legal fee application. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The other parties will have fifteen (15) days following the mailing date of the application within which to file objections. If no response is received within this fifteen day period, the parties will be deemed to have waived all objections to the fee requested.

In preparing the attorney fee schedule, the attention of counsel is directed to the provisions of Sections 725.365 and 725.366. In conjunction with each of those regulations and in considering applicable case law, IT IS ORDERED that the fee petition filed in this case shall include each of the following:

1. A complete statement of the extent and character of each separate service performed shown by date of performance;

2. An indication of the professional status (e.g., attorney, paralegal, law clerk, lay representative or clerical) of the person performing each quantum of work and that person's customary billing rate;

3. A statement showing the basis for the hourly rate being charged by each individual responsible for the rendering of services;

4. A statement as to the attorney or other lay representative's experience and expertise in the area of Black Lung law;

5. A listing of reasonable unreimbursed expenses, including travel expenses; and

6. A description of any fee requested, charged or received for services rendered to the Claimant before any State or Federal Court or Agency in connection with a related matter.

A

Rudolf L. Jansen
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).